Dental Expenses Not Covered

The plan will not provide benefits for any of the items listed in this section. This list is intended to give you a general description of expenses for services and supplies not covered by the plan.

- Services rendered by anyone other than a covered *dental care provider*.
- Any portion of a charge which exceeds the *usual and customary charge* for the geographic area in which services are rendered.
- Any service, supply or treatment which does not meet the standards accepted by the American Dental Association (ADA).
- Services or supplies for which there is no legal obligation to pay, or charges which would not be made except for the availability of benefits under the plan.
- Services furnished by or for the U.S. government or any other government, unless payment is legally required.
- Any condition, disability or expense sustained as a result of being engaged in: an illegal occupation, commission or attempted commission of an assault or other illegal act, intentional or accidental atomic explosion or other release of nuclear energy, whether in peacetime or wartime, participation in a civil revolution or a riot, duty as a member of the armed forces of any state or country or a war or act of war which is declared or undeclared.
- Any condition or disability sustained as a result of being engaged in any activity primarily for wage, profit or gain, and that could entitle the covered person to a benefit under the Workers' Compensation Act or similar legislation.
- Services or supplies which are primarily cosmetic or experimental in nature.

- Expenses for preparing dental reports, itemized bills or claim forms.

- Mailing and/or shipping and handling charges.

- Charges for broken appointments or telephone calls.

- Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any covered family member in the armed forces of a government.

- Professional services performed by a person who ordinarily resides in your household or who is related to the covered person, such as a spouse, parent, child, brother, sister, or in-law.

- Any services received from a Health Maintenance Organization (HMO) if the individual is a participant in the HMO.

- Expenses used to satisfy plan deductibles.

- Expenses eligible for consideration under any other plan of the *employer*.

- *Expenses incurred* for services rendered prior to the date of coverage under this plan.

- Training, educational instruction or materials relating to dietary counseling, personal oral hygiene or dental plaque control.

- Dentures and/or bridgework (including crowns and inlays forming abutments) when the charges are incurred for teeth extracted prior to the effective date of coverage under this plan.

- Prescription drugs.

- The replacement of a lost, stolen or missing prosthetic device.

- Services and supplies for personalization or characterization of prosthetic devices.
- Orthodontic services and/or treatment.
- Procedures and appliances to increase vertical dimension or restore occlusion.
- Tooth implants.
- Myofunctional therapy.
- Athletic mouth guards.
- Duplicate prosthetic devices or appliances.
- Treatment, by any means, of jaw joint problems including temporomandibular joint dysfunction syndrome (TMJ) and other craniomandibular disorders, or other conditions of the joint linking the jawbone and skull, and the muscles, nerves and other tissues related to that joint.
- Services related to an *active course of orthodontic treatment.*
- Procedures or appliances to stabilize periodontally involved teeth.
- Precision or semi-precision attachments.
- Periodontal splinting.
- Veneers.
- *Hospital* charges.
- Expenses for services performed after the date coverage ends under this plan.

SHORT-TERM DISABILITY BENEFITS

Benefit Payment

After the plan receives satisfactory evidence from your *physician* that you are *totally disabled* due to an accidental *injury* or *illness*, the plan will pay the weekly disability income benefit for which you are eligible. You must be under a *physician's* regular care and attendance to receive benefits.

During any one period of disability, you will be paid a minimum of $20 and a maximum of $500 per week, for up to 13 weeks. However, in no case will benefits exceed 60% of your weekly earnings. Benefits start from the seventh day if your disability is due to an *accident* or an *illness*. Benefits for less than a week are based on 7 days. All benefit amounts are rounded to the nearest dollar.

Payments will be made to you and will continue until you have recovered or reached your benefit maximum.

Successive Disabilities

Successive periods of *total disability* due to the same or related causes will be considered one period of disability, unless separated by your return to active, full-time service for at least 1 week. Successive periods of disability due to entirely unrelated causes will be considered one period of disability, unless separated by your return to active, full-time service for at least 1 week.

Limitations

Only one benefit is paid for a disability due to both an accidental *injury* or *illness*, or two or more *injuries* and *illnesses*. Reoccurrence of a disability which was originally due to an *accident* is considered an *illness*.

Expenses Not Covered

The benefit described above does not include:

- Disability occurring as a result of intentional, self-inflicted *injury* or *illness* while sane or insane.

- Any condition, disability or expense sustained as a result of being engaged in: an illegal occupation, commission or attempted commission of an assault or other illegal act, intentional or accidental atomic explosion or other release of nuclear energy, whether in peacetime or wartime, participation in a civil revolution or a riot, duty as a member of the armed forces of any state or country or a war or act of war which is declared or undeclared.

- Any condition or disability sustained as a result of being engaged in an activity primarily for wage, profit or gain, and that could entitle the covered person to a benefit under the Worker's Compensation Act or similar legislation.

- Any day on which you are not under the care of a *physician.* A period of care will not be considered to have started until you have been seen and treated personally by the *physician.*

- Benefits will not be provided for any disability which began prior to your effective date of coverage.

Termination Of Short Term Disability Coverage

Your short-term disability coverage under this plan ends the earliest of the date the group health plan ends, your employee class is excluded, contributions end, you are no longer eligible or you are dismissed or leave employment. For a leave of absence other than a disability leave, coverage ends the day prior to the day the leave starts.

Extension Of Benefits

If coverage ends while you are receiving benefit payments, payments will continue until you recover or have reached your benefit maximum.

PRESCRIPTION DRUG PLAN

About Your Prescription Drug Benefit

The prescription drug benefit is an independent program, separate from your regular medical plan and administered by APS. This provision is included for descriptive purposes only. You must refer to the actual provision in the literature prepared and distributed by APS for a complete description of covered and not covered expenses.

The APS plan provides benefits only for drugs or medicines prescribed by a *physician* but not to exceed a 34-day supply or 100 unit doses, whichever is greater.

The prescription drug benefit cannot be assigned regardless of the assignment provision in Other Important Plan Provisions.

Participating Pharmacy

The APS plan provides benefits only for a participating pharmacy's wholesale cost plus dispensing fee. A participating pharmacy is a pharmacy which has entered into a prescription drug plan agreement with APS.

Non-Participating Pharmacy

The APS plan provides benefits only for covered expenses that are equal to or less than the *usual and customary charge* of a participating pharmacy.

Prescription Drug Deductible

A prescription drug deductible is the amount of covered expenses you must pay for each prescription before the plan will make payments. The APS deductible does not accumulate toward any other plan deductible or out-of-pocket maximum.

The deductible amounts for the APS plan are $7 per generic prescription or refill and $12 per brand-name prescription or refill.

MAIL SERVICE PRESCRIPTION DRUG PROGRAM

The mail service prescription drug program is offered when there is an ongoing need for medication. By using this service, you can obtain prescribed medication required on a non-emergency, extended-use basis. The quantity of a prescribed drug ordered through this program can be anything up to a 90-day supply.

Prescription drugs obtained through this program are not subject to the medical plan deductible. However, you are required to pay $7 per generic prescription or refill and $12 per brand-name prescription or refill. The amount you must pay for each mail-order prescription does not accumulate toward the medical plan deductible or out-of-pocket maximum.

Prescribed medications which are covered by your prescription drug plan are also covered by the mail service prescription drug program if they are normally available at your local pharmacy. However, certain medications cannot be supplied by mail easily (for example, drugs requiring constant refrigeration) and are not available through this program.

The law requires that pharmacies dispense the exact quantity prescribed by the *physician*. So if your *physician* authorizes the maximum order quantity, the prescription must be for a 90-day supply for you to receive that quantity. For example, if you take one tablet per day, your *physician* must write a prescription for 90 tablets. If you take two tablets per day, your *physician* must write a prescription for 180 tablets, etc. If your *physician* authorizes refills, these can be dispensed only when your initial order is nearly exhausted, so be sure to ask your *physician* to prescribe the normal supply, plus refills whenever appropriate.

When you order by mail, your prescription is reviewed by a pharmacist, checked for drug interactions, dispensed and verified by quality control before it is mailed to you.

There will be times when you need a prescription immediately. On these occasions, you should have your prescription filled at a local pharmacy using your APS card. If you need medication immediately but will be taking it on an ongoing basis, ask your *physician* for two prescriptions. The first should be for a 14-day supply that you can have filled at a local pharmacy; the second prescription should be for the balance, up to a 90-day supply. Send the larger prescription with your co-payment of $7 per generic prescription or refill and $12 per brand-name prescription or refill through the Sinclair Broadcast Group, Inc. mail service prescription drug program.

NOTE: Certain controlled substances and several other prescribed medications may be subject to other dispensing limitations and to the professional judgment of the pharmacist.

COORDINATION OF BENEFITS

General Provision

When you and/or your dependents are covered under more than one group health plan, the primary plan will determine benefits first without regard to benefits provided under any other group health plan.

When this plan is the secondary payor, the plan will coordinate payment with the primary plan in such a way that when this plan's payment is combined with the primary plan's payment, the total does not exceed the amount this plan would have paid if it were primary.

Federal Programs

The term group health plan includes the Federal programs Medicaid and CHAMPUS. The regulations governing these programs take precedence over the order of determination of this plan.

Automobile Insurance

Benefits payable under this plan will be coordinated with benefits provided or required by any no-fault automobile insurance statute, whether or not a no-fault policy is in effect, and/or any other automobile insurance.

Other Group Plans

Any group health plan which does not contain a coordination of benefits provision will be considered primary.

When all plans covering you and/or your dependents contain a coordination of benefits provision, order of payment will be as follows:

If a person is covered under a plan as an active employee, that plan will be primary over a plan covering the same person as a dependent, a retiree or laid-off individual.

When a person is an active employee under more than one plan, the plan covering the individual for the longer period of time will be considered primary.

The plan covering a person as an employee or a dependent will be primary over the plan providing continuation coverage (COBRA).

A plan covering a person as a dependent child of non-divorced or non-separated parents will be primary according to which parent has the earlier birth date (month and day) in the year. If both parents have the same birth date, the plan covering the child for the longer period of time will be primary.

Children Of Divorced Or Separated Parents

When all plans covering a person as a dependent child of divorced or separated parents contain a coordination of benefits provision, the order of payment will be:

> The plan covering the dependent child of the natural parent designated by court order to be responsible for the child's health care expenses will be considered primary.
>
> In the absence of a court order specifying otherwise, the plan covering the dependent child of the natural parent having legal custody of the child will be considered primary.
>
> In the absence of a court order specifying otherwise, the plan covering the dependent child of a stepparent who is the spouse of the natural parent having legal custody of the child will be considered primary.

Right To Make Payments To Other Organizations

Whenever payments which should have been made by this plan have been made by any other plan(s), this plan has the right to pay the other plan(s) any amount necessary to satisfy the terms of this coordination of benefits provision. Amounts paid will be considered benefits paid under this plan and, to the extent of such payments, the plan will be fully released from any liability regarding the person for whom payment was made.

Assignment Of Benefits

All benefits payable by the plan may be assigned to the provider of services or supplies at your option. Payments made in accordance with an assignment are made in good faith and release the plan's obligation to the extent of the payment.

Special Election For Employees And Spouses Age 65 And Over

If you remain actively employed after reaching age 65, you or your spouse may choose to remain covered under this plan without reduction for *Medicare* benefits or designate *Medicare* as the primary payor of benefits. If you choose to remain covered under this plan, this plan will be the primary payor of benefits and *Medicare* will be secondary. If you choose *Medicare* as primary, coverage under this plan will end. If you do not specifically choose one of the options, this plan will continue to be primary.

If you are under age 65 and your spouse is over age 65, he or she can make their own choice.

Acts Of Third Parties

This provision applies if it appears you or your dependent(s) may have suffered *illness* or *injury* because of an act or omission of a third party. If you recover expenses from a third party by legal judgment, settlement or any other means, you must reimburse the plan for expenses paid by the plan relating to the *illness* or *injury*.

No benefits will be paid until you complete and sign a statement, provided by the plan, agreeing to reimburse the plan if these expenses are recovered from a third party.

Recovery Of Excess Payments

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of this plan, the plan has the right to recover these excess payments from any individual (including yourself), insurance company or other organization to whom the excess payments were made or to withhold payment, if necessary, on future benefits until the overpayment is recovered.

Further, whenever payments have been made based on fraudulent information provided by you, the plan will exercise their right to withhold payment on future benefits until the overpayment is recovered.

Right To Receive And Release Necessary Information

The plan may, without the consent of or notice to any person, release to or obtain from any organization or person, information needed to implement plan provisions. When you request benefits, you must furnish all the information required to implement plan provisions.

Alternate Payee Provision

Under normal conditions, benefits are payable to you and can only be paid directly to another party upon signed authorization from you. If conditions exist under which a valid release or assignment cannot be obtained, the plan may make payment to any individual or organization that has assumed the care or principal support for you and is equitably entitled to payment.

The plan may also honor benefit assignments made prior to your death in relation to remaining benefits payable by the plan.

Any payment made by the plan in accordance with this provision will fully release the plan of its liability to you.

FILING A CLAIM

How To File A Claim

The appropriate claim forms and identification cards may be obtained directly from Sinclair Broadcast Group, Inc. The following general steps should be followed in order to file a claim:

1. Complete the employee portion of the claim form in full. Answer all questions, even if the answer is "none" or "N/A" (does not apply).

2. Attach all necessary documentation of expenses to the claim form.

   Documentation must include:

   - a description of services or supplies provided, detailing the charge for each supply or service;
   - the diagnosis;
   - the date(s) of service;
   - the patient's name;
   - the provider's name, address, phone number and degree;
   - the federal tax identification number of the provider.

3. Complete a separate claim form for each person for whom benefits are being requested.

4. If another plan is the primary payor, a copy of the other plan's Explanation of Benefits (EOB) must accompany the claim form sent to this plan.

5. Mail completed claim forms to:

ALTA Health Strategies, Inc.
100 So. Charles St, 10th Floor
Baltimore, MD 21201

6. If you have questions regarding a claim, please call:

1-800-444-2627

All claims must be filed with the plan within a 12-month period from the date of the expense.

How To Appeal A Denial Of Benefits

If you believe a claim was improperly settled, the following process is available:

1. Within 60 days of receipt of the claim, you may request, in writing or verbally, that the plan conduct a review of the processed claim. The plan will review the processed claim and inform you whether or not an error was made. Any errors will be corrected promptly.

2. If you are not satisfied with the above review, a written request for a second review may be submitted to the plan within 60 days of the first review. The request should state, in clear and concise terms, the reason for disagreement with the way the claim was processed. When the written request is received, the claim will be reviewed again and the results of this review furnished in writing to you within 60 days in most cases, but in no case more than 120 days.

All requests for a review of denied benefits should include a copy of the initial denial letter and any other pertinent information. Send all information to:

ALTA Health Strategies, Inc.
100 So. Charles St, 10th Floor
Baltimore, MD 21201

Requests for appeal which do not comply with this procedure will not be considered, except in extraordinary circumstances.

OPTIONAL CONTINUATION OF COVERAGE

Continuation Of Coverage Under Federal Law

As mandated by Federal law, the plan offers optional continuation coverage to you and/or your dependents if coverage would otherwise end due to one of the following events:

- Termination of your employment for any reason except gross misconduct. Coverage may be continued for you and your eligible dependents.
- A reduction in hours worked by you which results in loss of plan eligibility. Coverage may be continued for you and your eligible dependents.
- Your death. Coverage may be continued for your eligible dependents.
- Divorce or legal separation from your spouse. Coverage may be continued for that spouse and your eligible dependents.
- You become entitled to *Medicare*. Coverage may continue for eligible dependents who are not entitled to *Medicare*.
- Loss of eligibility of a covered dependent child due to plan eligibility requirements. Coverage may be continued for that dependent.

NOTE: To choose this continuation coverage, an individual must be a covered person under the plan on the day before the qualifying event.

Notification Requirement

You or the qualifying individual has the responsibility to inform the *plan administrator* of a divorce, legal separation, or a child losing dependent status under the Sinclair Broadcast Group, Inc. Employee Benefit Health Plan High Option within 60 days of the qualifying event. Failure to provide this notification within 60 days will result in the loss of continuation coverage rights.

Your *employer* has the responsibility of notifying the *plan administrator* of your death, termination of employment, reduction in hours or entitlement to *Medicare* within 30 days of the qualifying event.

The plan will notify you or the qualifying individual of continuation coverage rights within 14 days of the notice described above. You will then have 60 days to elect continuation coverage. Failure to elect continuation coverage within 60 days after you are notified by the *plan administrator* will result in loss of continuation coverage rights.

Maximum Period Of Continuation Coverage

The maximum period of continuation coverage for individuals who qualify due to termination of employment or reduction in hours worked is 18 months from the date of the qualifying event.

If a qualifying individual is disabled (as determined under the Social Security Act) at the time of your termination or reduction in hours, continuation coverage for the qualifying individual may be extended to 29 months provided you notify the *plan administrator* within the 18-month continuation coverage period and within 60 days after you receive notification of disability. This extension of coverage will be effective only if your original 18-month continuation coverage period expires after November 1, 1990.

The maximum period of continuation coverage for individuals who qualify due to any other described qualifying event is 36 months from the date of the qualifying event.

If an individual experiences more than one qualifying event, the maximum period of coverage will be computed from the date of the earliest qualifying event, but will be extended to the full 36 months if required by the subsequent qualifying event.

However, if your spouse and dependent children would otherwise lose coverage because of a qualifying event, they will be entitled to 36 months of continuation coverage from the date you become entitled to *Medicare* even if your entitlement to *Medicare* does not cause you to lose coverage either because you are still employed or because you had already terminated employment. This provision is effective only for *plan years* beginning after December 31, 1989.

Cost Of Continuation Coverage

The cost of continuation coverage is determined by your *employer* and paid by the qualifying individual. If the qualifying individual is not disabled, the applicable premium cannot exceed 102% of the plan's cost of providing coverage. The cost of coverage during a period of extended continuation coverage due to a disability cannot exceed 150% of the plan's cost of coverage.

You or the qualified individual must make the first payment within 45 days of notifying the plan of selection of continuation coverage. Future payments can be made in monthly installments within 30 days of the due date unless your *employer* establishes a longer payment schedule. Rates and payment schedules are established by your *employer* and may change when necessary due to modifications.

The cost of continuation coverage is computed from the date coverage would normally end due to the qualifying event.

Failure to make the first payment within 45 days or any subsequent payment within 30 days of the established due date will result in the permanent cancellation of continuation coverage.

When Continuation Coverage Ends

Continuation of coverage ends on the earliest of:

- The date the maximum continuation period expires.
- The date the qualifying individual becomes entitled to coverage under *Medicare*.
- The last period for which payment was made when coverage is canceled due to non-payment of the required cost.
- The date the *employer* no longer offers a group health plan to any of its employees.
- The date the qualifying individual becomes covered under any other group health plan that does not exclude or limit coverage for a pre-existing condition the qualifying individual may have.

  If an individual obtains continuation coverage as a result of a qualifying event that occurred before January 1, 1990, continuation coverage will end on the date the qualifying individual becomes covered under any other group health plan even if it excludes or limits coverage for a pre-existing condition. However, if a qualifying individual with a pre-existing condition paid (or attempted to pay if payment was rejected) for continuation coverage elected after December 31, 1988, continuation coverage will not end even if the qualifying individual becomes covered by another plan that excludes or limits coverage for the pre-existing condition.

Conversion Privilege

When normal coverage or continuation coverage ends, group coverage may be converted to an individual health insurance policy which requires you to pay the premium.

If a qualified individual's continuation coverage ends as a result of the expiration of the maximum coverage period, the group health plan will, during the 180 days prior to the expiration date, offer the qualified individual the option of enrolling under a conversion health plan if such a plan is offered to active employees under the group health plan.

If an individual is converting from normal coverage, application must be made within 31 days after coverage ends.

In order to receive a converted health policy the following conditions must be met:

- The person must have been covered for at least 3 months prior to termination of coverage.
- The application and premium payment must be made within a 30-day time period.

DEFINITIONS

The following terms define specific wording used in this plan. These definitions should not be interpreted to extend coverage unless specifically provided for under previously explained provisions of this plan.

Accident

An unforeseen and unavoidable event resulting in an *injury* which is not due to any fault of the covered person.

Active Course of Orthodontic Treatment

The period of time which begins when the first orthodontic appliance is installed and ends when the last active appliance is removed.

Actively at Work (Active Employment)

You are considered to be *actively at work* when performing in the customary manner all of the regular duties of your occupation with the *employer*, either at one of the *employer's* regular places of business or at some location to which the *employer's* business requires you to travel to perform your regular duties or other duties assigned by your *employer.* You are also considered to be *actively at work* on each day of a regular paid vacation or non-working day on which you are not *totally disabled*, but only if you are performing in the customary manner all of the regular duties of your occupation with the *employer* on the immediately preceding regularly scheduled work day.

Age Discrimination

A violation of the Social Security Act, which states that all active employees and their covered dependents age 65 and over are entitled to the same and/or equal benefits they had prior to age 65.

Alternate Procedure

The most cost effective treatment of a dental condition which will provide a professionally acceptable result as determined by national standards of dental practice. Consideration is given to the current clinical oral condition based upon the diagnostic material submitted by the *dentist*.

Ambulatory Surgical Facility

A public or private facility, licensed and operated according to the law, which does not provide services or accommodations for a patient to stay overnight. The facility must have an organized medical staff of *physicians*; maintain permanent facilities equipped and operated primarily for the purpose of performing surgical procedures; and supply registered professional nursing services whenever a patient is in the facility.

Amendment (Amend)

A formal document signed by the representatives of Sinclair Broadcast Group, Inc. The *amendment* adds, deletes or changes the provisions of the plan and applies to all covered persons, including those persons covered before the *amendment* becomes effective, unless otherwise specified.

Benefit Year

The 12-month period beginning January 1 and ending December 31. All annual deductibles and benefit maximums accumulate during the *benefit year*.

Birthing Center

A public or private facility, other than private offices or clinics of *physicians*, which meets the free standing birthing center requirements of the State Department of Health in the state where the covered person receives the services.

The *birthing center* must provide: a facility which has been established, equipped, and operated for the purpose of providing prenatal care, delivery, immediate postpartum care and care of a child born at the center; supervision of at least one specialist in obstetrics and gynecology; a *physician* or certified nurse midwife at all births and immediate postpartum period; extended staff privileges to *physicians* who practice obstetrics and gynecology in an area *hospital*; at least 2 beds or 2 birthing rooms; full-time nursing services directed by an R.N. or certified nurse midwife; arrangements for diagnostic x-ray and lab services; the capacity to administer local anesthetic or to perform minor *surgery*.

In addition, the facility must only accept patients with low risk pregnancies, have a written agreement with a *hospital* for emergency transfers and maintain medical records on each patient and child.

Chiropractic Services

The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

Complications of Pregnancy

Conditions (when the pregnancy is not terminated) whose diagnosis are distinct from pregnancy but which are adversely affected by pregnancy or caused by pregnancy such as: acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. *Complications of pregnancy* also include a non-elective caesarean section, an ectopic pregnancy which is terminated, or spontaneous termination of pregnancy which occurs during a period of gestation when a viable birth is not possible; and, pernicious vomiting (hyperemesis gravidarum) and toxemia with convulsions (eclampsia of pregnancy).